ATTENDING PHYSICIAN'S STATEMENT

State Form 17296 (R2 / 1-02)
Approved by the State Board of Accounts 2002

INDIANA STATE TEACHERS'RETIREMENT FUND
150 West Market Street, Suite 300
Indianapolis, Indiana 46204-2809
Telephone (317) 232-3860 / Toll Free: (888) 286-3544
Home Page: www.in.gov/trf

This form must be delivered by the applicant to the attending physician. It must be made in the handwriting of the physician and mailed by him/her to the Teachers' Retirement Fund Board of Trustees. Applicant must make any payment for this statement. This statement must be filed before a disability application will be considered.

PRIVACY NOTICE

Your Social Security number is requested by this agency in accordance with the requirements of IRS Code 3405. Disclosure is mandatory; this form will not be processed without this information.

PRIVACY NOTICE			
Patient Name (Last, First, Middle)		**Social Security Number**	**TRF Number**
Date of Birth (MM/DD/YY)	**Marital Status (circle one)** **Married** **Single**	**Sex (circle one)** **Male** **Female**	**Phone Number** **( ) -**

PATIENT HISTORY	
How long have you personally known patient?	**Date of your first visit with patient for illness claimed to have brought about present condition?**
Number of visits?	**Date of last visit?**
What organ, system, or parts of the body have been attacked?	
Describe fully the course of the disease—its initial symptoms—history of its progress.	
Has patient suffered from any ailments other than those above mentioned? If so, describe each case, and state how long it lasted and if recovery was complete?	
Has patient been attended to or prescribed for by any other physician or surgeon with-in three years? If so, what was the reason? Give name and addresses of all such physicians and surgeons:	
Is patient wholly and continuously unable to perform any work, or follow any occupation for compensation or profit?	
If so, how long has patient been totally disabled?	

CONTINUED ON REVERSE SIDE

If not so disabled, is patient wholly and continuously unable to perform the work of a public school teacher?
Is the disability, in your opinion, likely to be temporary; permanent and total; or permanent and partial?
Please give any other facts or information, which in your judgment will aid in the correct solution of the claims presented.
How long have you practiced as a physician and where did you receive your medical education?

Signature of Physician		**Printed Name of Physician**	**Date**
Signature of Patient for the release of this information		**Printed Name of Patient**	**Date**
Address of Physician		**City**	
State	**ZIP**	**Phone Number** ( ) -	